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ABSTRACT

The paper describes Project RHISE (Rockford Handicapped Infant Services Expansion), a program to develop an effective early intervention program for infants residing in the lower socioeconomic areas and rural communities of Rockford, Illinois. Sections address a description of the model, rationale for the model, and theoretical aspects of the model. It is explained that the child, teacher, and parents comprise the triad through which such services as identification, assessment, program formulation and implementation, and child reassessment are provided. Consultation, on which Project RHISE is based, is discussed in terms of prerequisite staff competencies, the consultant-consultee relationship, preparation for consultation, and the process of consultation. An additional section outlines the dynamics of the consultancy model and concepts of consultation. (SBH)

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The Consultancy Model:

Concept and Procedure

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Consultancy: The Concept

Past and Present Perspectives

Providing competent, experienced staff and quality programs for developmentally delayed and handicapped infants is challenging in an urban setting, and even more so in widely scattered, sparsely populated areas. This very special group of young children needs the professional services of a variety of experts. Difficulties in providing the highly specialized services the children need often center around three factors:

1. manpower shortages in the specialized fields of pediatric physical therapy, occupational therapy, and speech and language pathology.
2. funding limitations to hire specialized personnel.
3. logistical problems of providing services to infants and their families in sparsely populated areas.

Project RHISE (Rockford Handicapped Infant Services Expansion) was funded in 1974 by BEH/HEW for the purpose of developing a demonstration model of service to infants residing in areas that are effected by the service limitations listed above. The Project's focus for the initial three-year grant was to provide an effective early intervention program for infants residing in the lower socio-economic areas and rural communities in the fifty-mile radius around Rockford, who were largely unserved by the Project's parent agency, Children's Development Center. The model had to be cost-effective, and it targeted adaptation to the common factors that limit quality programming: manpower shortages, funding limitations, and logistical problems.

Description of the Model

The model of service designed by Project RHISE to overcome these difficulties is called the Consultancy Model. It is a design for birth to three programming that rests firmly on an interdisciplinary foundation. A teacher has primary responsibility for implementing the children's programs, and does so only with the continual interaction of the program's clinicians. The process through which the teacher and clinicians work together to provide service becomes the Consultancy Model.

The model includes provisions for identification, assessment, program formulation, program implementation, and reassessment of children who are eligible for educational and therapeutic intervention. At each stage of this cyclical process the teacher and clinical staff are mutually involved (see figure 1).

The child, teacher, and parents comprise the triad through which most direct intervention takes place. At the heart of the program model is a routine program event called consultation. It is a sophisticated process of interaction in which the teacher and clinician(s) participate to exchange information relative to individual children's treatment programs. Routine, case-specific consultations create a continuing flow of specific information to the teacher which enables her to carry out specific interventions with a child and his family. In the direct consultation process, professional accountability is not relinguished. Each clinician is involved and accountable throughout the process, remaining responsible for transmission of information and monitoring the effectiveness of the integration of that information within the intervention program. The entire team shares responsibility for intervention, and the therapeutic impact is sustained.

Rationale for the Model

It is unrealistic to expect any one individual to have all the necessary knowledge and competencies required to provide a successful program of intervention for delayed and handicapped infants. The Consultancy Model was designed in the belief that a competent early childhood teacher educated in the principles of growth and development can provide quality services to the handicapped infant and his family, with the assistance of a team of competent clinicians.

It is really the most cost-effective for the teacher rather than the clinician to be the person who spends considerable time planning and providing routine intervention activities, keeping extensive notes to document progress, and traveling around the service area. The clinician will have maximum effect on the greatest number of children by assessing and reassessing them, designing programs to meet their needs, monitoring the provisions of those programs, and providing those interventions which are either inappropriately released to other professionals or too complex for others to perform.

In addition, limiting the number of professionals who routinely interact with the parent and infant may beneficially effect the formation of normal attachments between them. Una Haynes (director of the National Collaborative Infant Project) suggests that the child with multiple dysfunctions is already at risk for the formation of normal attachment patterns due to the stress his family experiences as a result of his dysfunction. The segregate handling by a variety of interventionists, which is meant to be therapeutic, may actually impede the child's attachment to a single person, traditionally the parent, which is so characteristic and essential.[1]

Theoretical Aspects of the Model

As Project RHISE completed its refinement of the Consultancy Model, technical assistance was obtained for this purpose from Dorothy Hutchison, R.N. (Associate Professor of Nursing, University of Wisconsin-Extention, and consultant to the United Cerebral Palsy of America National Collaborative Infant Project). Ms. Hutchison identified the similarities between the Consultancy Model and the Transdisciplinary Approach, which was pioneered by the U.C.P.A. Infant Projects, under the leadership of Una Haynes.

An important similarity between the two models seems to be the concept of limiting the actual number of adults who deal with the atypical infant, even though he needs the professional services of a variety of disciplines[2]. In the Consultancy Model the professional service provider is usually the teacher, in conjunction with an interdisciplinary team of clinicians. Chanelling direct service through one person reduces compartmentalized and fragemented service. Chanelling direct service through the teacher is the most cost-effective method.

In the teaching-learning relationship that evolves between consultants and the teacher, various transdisciplinary components are in operation simultaneously. All parties are keeping abreast of new findings in their own fields (role enrichment); all are involved in role expansion - the deliberate pooling of information, knowledge, and skills; and role support occurs - complex interventions demanding extensive clinicial expertise or those interventions which can't be released are performed by the clinician and intervention based on new information or new patterns of practice will be tested by the appropriate clinician before transmitting to the teacher[3]. When basic teacher competencies are present and adequate practice under the direct supervision of the appropriate clinician has taken place, certain learned interventions can be carried out by the teacher (role release) and of course the parents, who are the primary programmers.

Consultation - The Procedure

Description of Consultation

Consultation is basically a cooperative relationship in which one professional assists another with a work-related concern[4]. The nature of the relationship is cooperative, confidential, and work-related[5]. The consultation is generally initiated by the consultee and usually involves just two people - the consultant and the consultee. However, the interaction may involve more than two people who are concerned with the child and may be initiated by the consultant if s/he identifies a need.

The immediate objectives of consultation focus on the development of a workable strategy for dealing with the current concern[6]. The long-term objectives for regular, on-going consultation target improved skills in the consultee for working effectively with similar situations in the future[7]. Therefore, a routine consultative process, when built into the natural flow of program events, becomes one method of meeting inservice needs.

Prerequisite Staff Competencies

Consultations are almost always case-specific. Information, knowledge, and skills are transmitted in relationship to the treatment plan of a particular child. In order for this highly specific information to be most meaningful, certain basic teacher competencies must be in place. These include:

1. An understanding of normal growth and development milestones and the corresponding techniques of developmental stimulation;
2. An understanding of the array of abnormal developmental conditions and the corresponding special techniques that facilitate the effects of routine developmental stimulation with children displaying these abnormal patterns;
3. Knowledge of the multiplicity of handicapping conditions which effect developmental progress in infancy and early childhood - their medical aspects and treatment implications.
4. A general understanding of the skill areas that each clinical discipline accepts responsibility for, specific terms and definitions each discipline uses frequently, and the general kinds of treatment techniques employed by the specific disciplines.

Consultants must also participate in the preparation for effective, long-term, intra-team communication by defining which areas commonly assigned to his/her discipline are better addressed by another clinician, due to the focus of his/her particular training and experience. In the clinical treatment of developmental disabilities in infants and young children, there can be overlap among the disciplines (e.g. facilitation of early feeding skills can often be equally done by speech clinicians, physical therapists, and occupational therapists) so that complete neglect of a skill is not a likely possibility when a multi-disciplinary team is present.

In summary, consultation is most effective when these teacher competencies are present. If lacking, they might be best established through a series of carefully planned inservice presentations before case-specific consulation is begun. The additional clarification from the consultants will complete the preparation.

The Consultant-Consultee Relationship

In the kind of program setting described herein, which calls for a generalist (supported by a clinical staff) to deliver services to children under age three, the role of the consultant will vary, depending upon the particular situation at

hand and the needs of the consultee. Consultations may range from collaborative problem solving sessions to a uni-directional approach in which information is given and specific skills and techniques are transferred from consultant to consultee.

Both of these methods, and styles in-between, have merit in the RHISE model. Regardless of the style of consultation employed, the relationship between consultant and consultee is marked by mutual trust and regard as colleagues. Both people are interested in the child for whom they share program responsibility. The consultative setting provides a safe atmosphere in which the teacher can share concerns and frustrations and verify his/her informal observations about current treatment status. Moral support is given and received. The relationship is a helping one.

Preparation for a Consultation

In preparing to request a consultation, the consultee needs to consider certain factors. Has this consultant specified that s/he is comfortable consulting on this type of concern? The selection of the consultant may be discipline-appropriate but the interests, expertise, or experiences particular to that consultant may not be related to the concern at hand. If a concern could appropriately be presented to two consultants, then a group consultation may be arranged.

A request for a consultation needs to be clearly made in writing (See Figure 2). The request should include the following information: 1) child's name, birthdate, and chronological age; 2) date, time and place of proposed consultation; 3) a brief summary of current status, including an informal estimate of developmental status, comments on social affect and behavior, an estimate of rate of progress, notes on pertinent medical aspects and comments on parental involvement with the child (current rapport with the child, skillfulness in working with the child, and personal or family matters that affect the child and his assimulation into the family); 4) statement about the consultee's desired outcome for the consultation (opportunity to verify impressions? new goals/activities for child's treatment? materials for parents? demonstration of a specific technique? written information to understand a condition or technique better?).

The form can be given to the consultant ahead of time to allow for adequate preparation. It can also be used during the consultation for notations and comments on planned follow-up. If the completed Consultation Record is typed and placed in the child's file, it becomes good documentation of program events between times when the program is thoroughly reviewed and revised.

One additional factor involved with insuring effective consultation is the need for the consultant to periodically have some kind of "direct" contact with the child. For the consultant to evaluate the child at entry into the program and not again until reassessment one year later is insufficient. In some cases, descriptive information on the child given by the consultee is sufficient. In other cases, it might be necessary for the consultant to view a recently filmed video-tape or hear a recently recorded audio-tape of the child. In other cases, there may be no substitute for direct, hands-on interaction between child and clinician. Even though the consultant is not routinely involved with direct treatment of the child, s/he will need occasional contact with the child to avoid consulting with an outdated image of the child.

The Process of Consultation

The actual process of direct consultation is structured by various describable components. Three distinct phases emerge: problem clarification; problem resolution or strategy generation; and provision for follow-up. The first phase, problem clarification, is built upon the information that was recorded by the consultee and given to the consultant ahead of time. Further efforts are made at defining the concern and the consultee's desired outcome for the session. Questioning is a most effective technique at this point. Information questions can be used to obtain the most useful information. The questions are open ended as opposed to ones that can be answered with a simple yes/no. Thoughts can be frequently clarified if the consultant attempts to check his/her understanding of the discussion by restating the information as s/he perceived it. Also, summarization of facts and conclusions periodically will help both participants clarify the consultation's status and direction.

After the concern and desired outcome have been clearly defined, the second phase begins, which is resolution or strategy generation. Bearing the desired outcome in mind, the consultant presents the needed information in the format desired. More than one strategy or piece of information will probably be helpful. The resolutions can be mutually generated or can come totally from the consultant. Provision for follow-up is the final phase. Here it is decided whether additional sessions might be necessary and what indicators will signal the need.

Throughout the consultative exchange, a positive atmosphere can be maintained if both participants are able to reinforce each other when useful information is exchanged. Both the consultant and consultee will need frequent reassurance that s/he is participating appropriately because consultation is a sophisticated and sometimes difficult undertaking. In addition, a healthy focus is one that centers on the fact that the teacher has a concern about something, not a problem with something, which intimates inadequacy. Finally, focus on the child, in contrast to the teacher's feelings about the situation, will keep the exchange objective and avoid changing it into a counselling situation, which may be appropriate but in another setting.

Summary

Consultation is the backbone of the RHISE approach to direct service. It is the enabling link that transmits training and support from an expert, multidisciplinary staff of clinicians to a teacher who assumes most of the responsibility for direct service to the children and their parents. It is a cost-effective way to serve infants and toddlers needing educational and therapeutic assistance. It is a dynamic, innovative way to provide services to special children in urban centers as well as sparsely-populated areas. It works and the children and their families benefit.

PROJECT RHISE/OUTREACH

CONSULTANCY MODEL

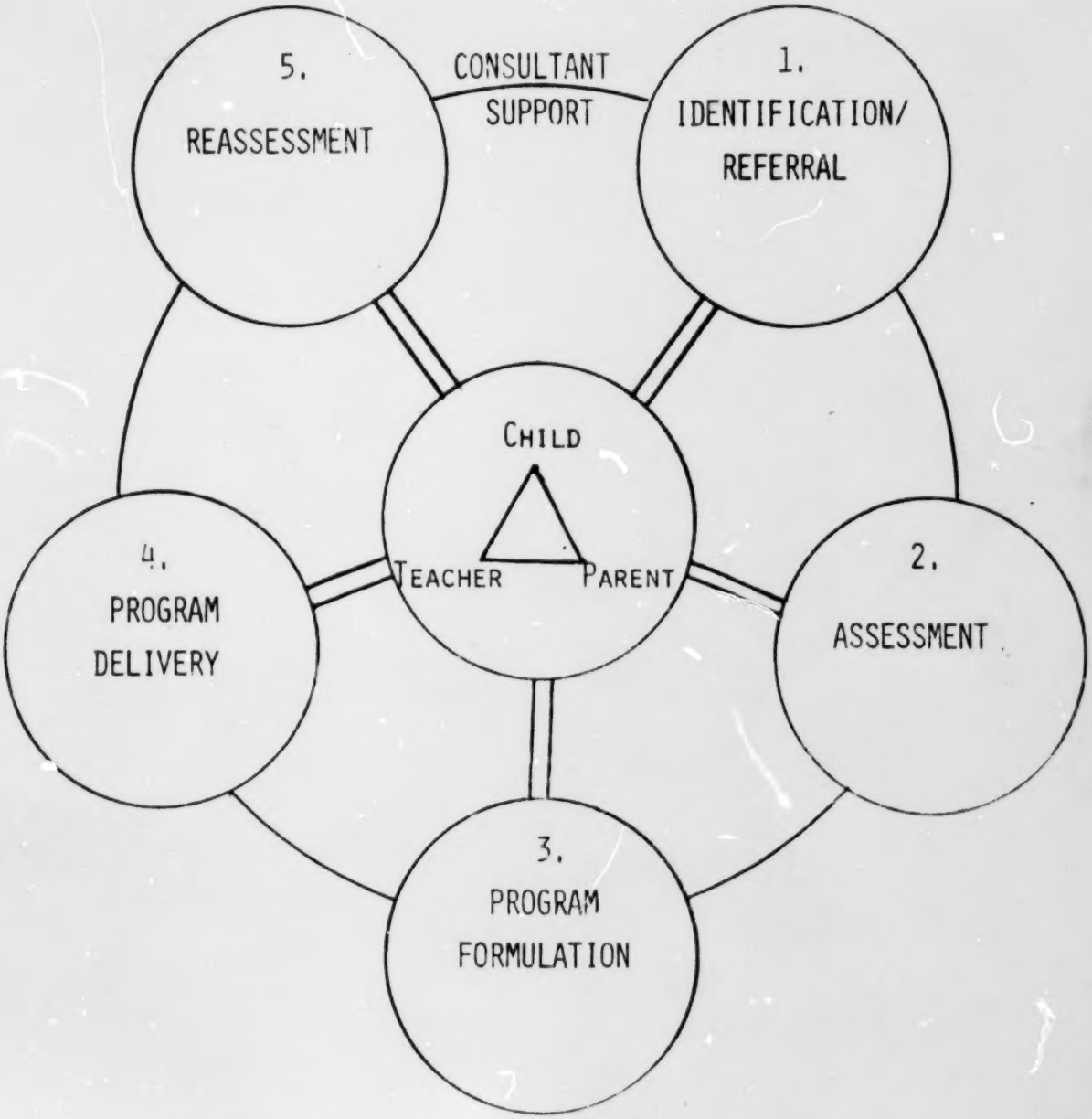

Figure 1

Project RHISE/Outreach
Children's Development Center
650 North Main Street
Rockford, Illinois 61103

Consultation Record

Child's Name: _____ Consultant(s): _____

Birthdate: _____ Date/Time: _____

Chronological Age: _____ Place: _____

Current Status (developmental, behavioral, medical, familial):

Reason for Consultation:

Desired Outcome:

Consultation Notes:

Follow-Up:

Figure 2

FOOTNOTES

[1]Una Haynes, "The National Collaborative Infant Project," Intervention Strategies for High Risk Infants and Young Children, (Baltimore: University Park Press) 1976.

[2]F.P. Connor, G.G. Williamson, and J.M. Siepp (eds.), Program Guide for Infants and Toddlers with Neuromotor and Other Developmental Disabilities, (New York: Teachers College Press) 1978.

[3]D.J. Hutchison and U. Haynes, Transdisciplinary: A Team Approach to Service for the Developmentally Disabled, (Thorofare, New Jersey: Charles B. Slack) publication pending.

[4]M.J. Curtis and T.E. Anderson from M. Curtis, M. Landers, K. Watson, and K. Jaffe, "School-Based Consultation: Issues and Techniques for Training," (A paper presented at the annual meeting of the Council for Exceptional Children, Kansas City, Missouri) May 1978.

[5]Ibid.

[6]Ibid.

[7]Ibid.

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Dynamics of the Consultancy Model

I. Consultancy: The Philosophy

The Consultancy Model is a design for birth-to-three programming that involves a team of transdisciplinary specialists working together in a unique way to implement children's programs which the team has designed. A teacher has primary staff responsibility for programming the children, but can do so only because of the continuing interaction with the clinical staff that occurs in routine, case-specific consultation. The ultimate goal of this unique interaction between teachers and clinicians is to assist parents in their role as primary teachers of their own children; for the most effective interaction will occur within the parent-child/teaching-learning relationship.

II. Consultation: The Enabler

Consultation is a routine (weekly) event in programs using the Consultancy Model. It is case-specific, child-centered, and highly structured. It is a helping service to those who carry direct responsibilities for action. A systematic sharing of information, knowledge, and skills across disciplines is accomplished through a combination of major inservice sessions and routine consultation.

III. Role Release / Role Support: The Challenge

Role Release: a disciplinary specialist training and authorizing a team member to provide intervention.

Role Support: a disciplinary specialist providing intervention directly

In the Consultancy Model, providing the expert intervention needed in the most efficient way possible requires a flexible balance between the transdisciplinary functions of role release and role support. Releasing knowledge, information and skills to teachers so they can assume primary staff responsibility for intervention is counter-balanced by those situations in which the disciplinary specialist provides role support to teachers by performing interventions directly.

The Consultancy Model was developed by Project RHISE/Outreach, a model early intervention program for handicapped and developmentally delayed infants and toddlers funded since 1974 by the Bureau of Education for the Handicapped (HEW) as part of the Handicapped Children's Early Education Program.

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Current Status (developmental, behavioral, medical, familial):

Reason for Consultation:

Desired Outcome:

Consultation Notes:

Follow-Up:

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Concepts of Consultation

Consultation is a routine event in programs using the Consultancy Model. It is case-specific, child-centered, and highly structured. A typical consultation between a teacher and a clinician will progress through stages similar to the following:

Problem Clarification

1. Statement of reason for consultation
2. Statement of desired outcome for consultation
3. Summary of information describing child's current status and environment

Problem Resolution

1. Strategy generation (mutual or unilateral) to identify alternative approaches
2. Presentation of new information and skills needed by consultee to carry out alternatives
3. Supervised practice with new information and skills to insure competency

Follow-up and Evaluation

1. Define behaviors to observe in the child that indicate whether approaches are effective or ineffective
2. Define limits within which information and skills can be applied
3. Set another consultation when approaches are ineffective or when limits of application have been reached